DEPARTMENT OF MEDICINE
PG2 AND PG3 YEARS

I. General

During the PG2 & PG3 years, the resident physician is expected to develop into a skilled general internist. The resident should also acquire the administrative and interpersonal skills necessary to manage an internal medicine section at a small Air Force hospital. The following guidelines outline the resident's responsibilities. The staff attending physician on each rotation is the primary supervisor and educator of the resident and may designate whatever additional guidelines he/she deems necessary.

II. Inpatient Medicine (Wards & ICU)

A. Ward and ICU team structure: Each PG2 or PG3 resident ("ward or ICU resident") works as day-to-day supervisor of a ward or ICU team. The ward team consists of one PG1 resident (intern), a PG2 or PG3 resident, medical students, and a staff internist or subspecialist ("attending physician"). The ICU team consists of three interns, a PG2 or PG3 resident, medical students, a pulmonologist, and a cardiologist.

B. Goals and Objectives: The goals and objectives of the ward and ICU rotations must be reviewed with the resident at the start of each rotation. Documentation that a discussion of the goals and objectives must be documented and will be kept on file in the Internal Medicine Education Office with the Coordinator. Goals should be behavioral, measurable and linked to evaluation at the end of the rotation.

C. Responsibilites:
   a. The resident is the leader of the ward or ICU team and is responsible for the actions of the intern(s) and medical students.
   b. The ward resident must keep the attending physician informed of all significant developments occurring in-patients under his/her care. Final authority and responsibility for patient care resides with the attending physician
   c. During their first month on the ward or in the ICU as a senior resident, PG2 residents will have an in-house PG3 supervising them for their first couple of call nights. The supervising PG3 during this time is required evaluate the new admissions, any patients transferred to the ICU, consults from other services and patients discharged from the Emergency Department. They will discuss the differential diagnosis and treatment plans with the PG2. They will not be required to write a note, but to review the Resident Admit Note, the H&P and the admitting orders. The PG3 resident must co-sign the Resident Admit Note. The supervising PG3 should also be available to help teach and observe the interns as well as the PGY-2 resident doing procedures.
   d. When supervising more than one first year resident, the second or third year resident must not be responsible for the ongoing care of more than 20 patients. Attending physicians bear the responsibility for patient care exceeding these limits.
   e. The resident should ensure that interns and medical students get to all conferences in a timely manner.

f. Ward and ICU PGY 2 and 3 residents are primarily responsible for medical student teaching.
g. The admitting/transferring resident will inform the appropriate ICU or CCU attending physician, of any admissions to the ICU/CCU, once the patient has been stabilized. Appropriate detail should be available to relay to the attending.

D. Teaching:
   a. The resident should act as a teacher for all members of the team.
   b. He/she should incorporate case oriented teaching into the daily routine, discuss new cases with the intern at the time of admission, clarify important historical points, demonstrate noteworthy physical findings, and review important radiographic and laboratory findings with the intern.
   c. The resident should help the intern to shape and structure differential diagnoses, and to streamline diagnostic and therapeutic strategies.
   d. Clinical procedures should be taught without taking over.
   e. The ward resident should provide useful literature to supplement basic textbook reading.

E. Intern Supervision:
   a. He/she should supervise and instruct each intern to ensure high quality patient care.
   b. The intern should be allowed and encouraged to function as the primary physician.
   c. The resident should be familiar with the Department's expectations of interns, as outlined in the "Guidelines for Interns", and should provide any and all assistance needed to help the intern meet these expectations.
   d. He/she must be available to the intern at all times while the team is on duty.
   e. Each block, the resident should observe each intern at least once as they perform a complete history and physical examination, and offer constructive feedback.
   f. With few exceptions, the interns should write all orders. However, residents must co-sign all admission, transfer and discharge orders during the first three months of the academic year.
   g. Medication cardexes and nursing care plans should be reviewed with the interns at least twice a week. Eliminate unnecessary nursing tasks that drive up the acuity level.
   h. The discharge plan and medications should be reviewed with the intern on each patient. Make sure a representative from the ward team attends weekly discharge planning rounds with the discharge planners.

B. Work Rounds: The resident leads work rounds with the intern(s) and medical students preceding openers at 0800 each day and should personally see each patient on the service. At that time the daily and long-term plans should be developed on all patients.

C. Attending Rounds:
   a. The resident must take part in attending rounds, which are held at the discretion of the attending physicians.
   b. The resident should work with the attending physician to organize these rounds so that all new patients can be discussed, and important teaching points made, within the allotted time.

c. He/she should ensure that the interns are prepared to give succinct oral presentations. The resident should have already assisted the intern in the formulation of a basic differential diagnosis and plan, and at attending rounds should be prepared to discuss pertinent information gathered from the medical literature.

a. Attending rounds must include four and a half hours of teaching per week and include bedside teaching. Bedside teaching may include review of physical findings, bloodsmears and/or radiology studies as well as modeling patient interviews.

D. Call:

a. The ward resident is responsible for in house call every fourth night, except for Sundays through Thursdays. Holidays will be covered by the ward resident (see night float responsibilities below).

b. Night Float: A resident (referred to "night float resident") will take over duties and function as the ward resident from 2000-0800 Sunday through Thursday. From 0700-0800 each morning the night float resident and the ward resident will discuss the patients admitted overnight. At 0800 that resident (now post call) will assume care for patients admitted overnight to his/her team.

c. ICU residents also take call every fourth night with the C-team except Sun-Thurs (see below).

d. Ward call starts at 0800 and ends at 0800 the next day.

e. During call, the ward resident supervises the interns on the team, responds to all Code Blues, and provides Internal Medicine consultation to the ER and all other hospital services. The ward resident on call performs an evaluation on all patients referred from the ER, PCC, etc for admission to the Medicine Service.

f. While on call the resident will also answer telephone calls from outpatients in the Internal Medicine Clinic via the PCM (primary care manager) beeper. Documentation of each call should be detailed in a Tcon and forwarded to the patient's PCM.

g. No opiods or other controlled substances are to be prescribed by the resident answering the PCM beeper. If the patient is in that much acute pain that opoids need to be given, then he/she should be evaluated. Chronic narcotics are not to be prescribed via the PCM beeper. If patients are on chronic narcotics, they need to call the clinic for refills during normal duty hours.

h. Ward residents must round with the ICU/CCU teams on the weekends.

E. Admissions:

a. Admissions are limited to 10 ward/ICU admits per resident in a 24-hour period or 16 in a 48-hour period. Any admission over 8 to the ward will be considered overflow admissions. ICU transfers do not count toward these caps. If night float exceeds 10 admissions or needs assistance overnight then that teams senior will provide backup.

b. MRAN:

i. The ward resident must complete and document an initial evaluation on all assigned patients as soon as possible following admission. This evaluation should include a complete assessment and plan but need not reiterate the medical history, physical examination, laboratory and radiographic data already documented in the intern's H&P. The evaluation should be recorded as a "medicine resident admission note" or MRAN in the progress note section of the inpatient chart. The admission note must conclude with a thorough discussion of the differential diagnosis and management plan for each major problem identified.

ii. Exceptions to these rules are patients admitted for procedures only (i.e., endoscopy, bronchoscopy, transfusions, etc). Each off these patients should be reviewed with the intern, but completion of a "resident admission note" is left to the discretion of the ward resident.

iii. In those instances when the PG2 or PG3 resident writes the H&P an additional MRAN is not necessary.

F. Transfers:

a. The ward resident on call will work closely with the attending physician on call in deciding appropriate in-hospital transfers from other services to the medicine service. In-hospital transfers are ultimately the responsibility of the attending physicians and require transfer notes by the transferring and accepting attending physician.

b. The ward resident on call should refer all decisions regarding potential transfers from other hospitals to the attending physician on call. The ward resident has the authority to accept patients from referring hospitals and clinics. Any refusals of transfer for whatever reason should be referred to the attending physician.

c. All transfers from another facility to the ICU must be approved by the MICU/CCU attending.

G. Consults:

a. The on call resident must present all off-service and ER consults to the ward team attending physician. Whenever indicated, the team will follow any inpatient consults as long as necessary.

b. A staff physician must co-sign all consults. For those patients seen in the ER and sent home, a copy of the consult should be left on the chart but the original should be brought to the attending to sign the next day on rounds.

c. Consults from the Primary Care Clinic (PCC):

i. If the MOD is called by the PCC for a consultation, there are several ways in which that consultative evaluation can take place: evaluating the patient in the PCC; evaluating the patient in the Internal Medicine Clinic; evaluating the patient in the ED; or admitting the patient directly. The majority of such consults will be seen in the PCC.

ii. If the MOD asks the PCC to send a consult patient to the ED, the MOD, rather than the ED staff, should conduct the consultative evaluation in the ED. If a patient is acutely ill, the ED staff will immediately begin stabilizing the patient whether or not the MOD is present. For less ill patients, the MOD can use the ED as a triage station to conduct the consult

and disposition the patient. The MOD can write orders in the ED, utilize the ED technicians and nursing, and so on. For patients the MOD directs from the PCC to the ED, the MOD should function as the "primary" evaluator in the ED (although such "primary" evaluation is really consultantship, as the primary evaluation occurred in the PCC). The intent is for the MOD to take ownership as a consultant when called. Once the Internal Medicine resident has been consulted the attending physician for that ward team becomes the attending of record. The MOD can elect to admit a patient directly and see them on the wards.

iii. The MOD can also ask the PCC to send a consult patient to the Internal Medicine Clinic (IMC) where the MOD can use IMC exam space and resources to perform the consultative evaluation. As always, communication remains critical to this process working smoothly.

H. ICU: The ICU resident will supervise the activities of all ICU interns and all patients and coordinate management rounds and didactic sessions with the ICU attending. The ICU resident will, along with the on call ICU intern, conduct the primary clinical evaluation and management for all patients requiring ICU/CCU care at presentation as well as those ward patients transferred to the ICU between 0800 and 1700 Monday through Friday. Additionally, patients presenting to the ED that require a cardiac evaluation will be the primary responsibility of the ICU team between 0800 and 1700 Monday through Friday. These patients may be placed on the ward according to the Chest Pain Guidelines (see attached), but followed by the CCU service. This applies to patients whose primary reason for admission is chest pain. If that is a secondary issue the patient should be admitted to the ward team with a cardiology consult as needed. Weekend ICU admissions will be the primary responsibility of the on call ward resident.

a. The ICU resident will take all PCM calls when the C team is on from 1700-0800.

I. Inpatient Record: The ward or ICU resident is responsible for maintaining the integrity of the inpatient record. The resident should review the inpatient records of all patients assigned to the ward or ICU team on a daily basis to ensure that the records meet all of the standards outlined in the "Guidelines for Interns".

a. The intern's initial evaluation and subsequent progress notes should be reviewed and the H&P cosigned by staff.

b. Resident progress notes should be written as necessary to show that a senior house staff member is aware of significant developments in a patient's course.

c. The residents should ensure that the intern can identify medical quality assurance occurrences that require activation of AF Form 2519 (“Incident Report”). If a patient is examined for an Incident Report the resident should ensure that a note is written in the inpatient record documenting that the patient was seen and examined but should not refer to the Incident Report as this is an internal document which is not part of the medical record.

d. The ward resident will dictate narrative summaries on all deaths, patients leaving AMA, MEB, or TDRL patients. All death summaries will be dictated within 24 hours.

e. Each ward resident is required to make weekly visits to clinical records to dictate, sign, or complete inpatient records. Leave will not be permitted if any records are outstanding for more than 60 days.

J. Subspecialty consultation: The ward resident should coordinate input from multiple consultants and ensures that requests for consultations by his/her team are timely and appropriate

K. Medical Students: When medical students are assigned to the ward team, the ward resident is responsible for providing a meaningful education experience, and for ensuring review and cosigning of notes and orders.

L. Sign-out: The resident must sign out to the resident on call before departing the hospital, informing them of any potential problems with patients on their team.

M. Work Limits: The resident and staff attending will ensure that the interns work no more that 80 hours per week and that each intern gets one day out of seven free from clinical duties (averaged across a four week period). Overnight call shifts can only be 24 hours with 6 additional hours the next day for teaching and transition. These work limits also apply to the resident.

N. Restraints: PG1 residents may not order initiation or renewal of restraints. A PG2 or PG3 must do this. However, it is important for the intern to become familiar with the indications and use of restraints. Refer to OI pertaining to restraints.

III. **Subspecialty Rotations**

A. The department recognizes that a resident needs exposure to a variety of medical subspecialties in order to become a well-rounded internist. However, it is not necessary for each resident to rotate through formal subspecialty electives in all areas. Every effort will be made to allow the resident to experience as many subspecialty rotations as scheduling constraints permit.
B. While on a subspecialty rotation, the duties of the resident will be determined by the responsible attending staff. The goals and objectives of the rotations must be reviewed with the resident at the start of the rotation. Documentation that a discussion of the goals and objectives will be tracked for accreditation purposes.
C. Residents on subspecialty electives are responsible for educating the house staff on the ward teams requesting consultation, and should provide access to pertinent medical literature.
D. Residents on subspecialty rotations should answer all in house consultations within 24 hours of receipt of the consult. This may be accomplished by a note in the chart indicating that evaluation is in progress, or with a complete and staffed consultation.
E. Residents may choose subspecialty rotations at other institutions. Elective rotations at other institutions must be projected at the beginning of the year. The preceptor/evaluator, the goals and objectives of the rotation and the daily schedule must be submitted at least 8 weeks in advance. While on these rotations, the residents' duties and responsibilities will

be defined by the attending staff and Chief of Residents of that institution. Specific additional guidelines for these extramural rotations are available from the Chief of Residents.

F. While on a consultation service, the resident may be tasked for other clinical duties (ward, ICU) should the need arise, at the direction of the Chief of Residents.

IV. **Outpatient Medicine Continuity Clinic**

A. In an attempt to provide comprehensive, ongoing, ambulatory patient care, PGY2 and 3 residents expand their continuity outpatient care established during their internship. Each PG2 and PG3 sees two half-day clinics weekly while on non-ward 4-week rotations and approximately 5 half-day clinics per 4-week rotation on the wards or in the ICU.

B. Board-certified internists staff the continuity clinics ("clinic preceptor"). The resident should present each patient to the preceptor and discuss the plan for management. The clinic preceptor reviews and co-signs the records of all patients seen by the resident

C. The resident is responsible for maintaining a problem oriented outpatient chart on each assigned patient, including a problem list & medication flow sheet (the summary of care form), and progress notes. The completed charts must be given to the responsible clinic preceptor for review and co-signature by the end of the day.

D. Cancellation or rescheduling of clinics needs to be approved by the Chief of Residents and will not be allowed except in emergencies.

E. The resident must check his/her CHCS Telephone consults (T-cons) and New Results in a timely manner for laboratory results or messages from patient who may require assistance. All Internal Medicine Clinic patient T-cons should be returned within 48 hours of receipt.

F. While away from DGMC TDY or on leave you must let the Residency Program Coordinator, Program Director, and Chief Resident know who is covering your telecons and lab results so they can keep the board a the front desk updated. Please also remind your covering resident to check your paper mail box periodically if your are gone for an extended period.

V. **Teaching Conferences**

Each resident is required to attend all teaching conferences except in cases of emergent patient care. Attendance at these functions will be monitored and all residents must sign-in on the attendance roster. Attendance is expected to at least 80% of the lectures while you are here. Please be on time, the speakers are doing this for your education.

A. Core curriculum lectures are held at noon Mondays, Wednesdays, and Thursdays in the medicine department conference room. Grand Rounds is held Fridays at noon in the fourth floor conference room. Attendance is also required at Clinical Pathologic Conferences (CPC), Military Unique Curriculum lectures, and Morbidity and Mortality Conferences. CPCs are held every other month on the 4th Monday in the auditorium at 1600.

B. Residents are required to attend "Morning Report," which is held each weekday 0800-0900 in the Medicine Conference Room.

C. Occasionally, residents will be expected to attend and present cases at other subspecialty conferences (e.g. Catheterization Conference, Chest Conference, Neuro Conference, Gl Conference, etc)

D. The Senior Resident Seminar will be done Tuesdays at noon. The agenda will reflect residents interests to possibly include board review, evidence-based medicine, hospital systems etc.
E. Residents will be expected to prepare and present a Grand Rounds and a journal club. In addition they will also prepare and run at least two Openers throughout the academic year. One of these openers will be in the style of the Clinicopathological conference in which residents will be expected to provide pathologic or radiologic correlation to their cases. The Chief of Residents will assign these.
F. Residents are encouraged to help educate other members of the healthcare teams in such venues as nursing inservices, ACLS instruction or giving lectures in Family Practice or the Primary Care Clinic.

VI. **Leave/TDY Policy**

A. Each PG2 and PG3 resident is allowed a total of 30 days of leave annually. Leave may be taken from any subspecialty consult service. Leave should be projected at the beginning of the academic year.
B. A coordination form must be obtained form the Department of Medicine training office and completed in full, including all necessary signatures, before leave is requested. All requests must be submitted at least four weeks in advance.
C. The resident is responsible for notifying the Internal Medicine Clinic appointment scheduler and the Chief of Residents of their leave request so that clinics will not be scheduled during that period. This needs to be done 8 weeks in advance. In addition, the resident is responsible for personally rescheduling outpatients in the Internal Medicine Clinic should these patients already be scheduled at the time the leave is requested. As well, each resident must find a colleague to 'cover' his/her T-cons and other outpatient clinical duties, which may arise, AND to designate him/her in CHCS as a surrogate provider. A note should be written on the residents door with the dates that he/she will be gone and the covering resident.
D. Requests for emergency leave should be made to the Chief of Residents and the Program Director as soon as the need arises or such leave becomes evident.
E. Adjustments in work requirements necessitated by illness or pregnancy will be determined on an individual basis by the Program Director and Residency Education Committee.

VII. **Research**

Residents must submit at least one abstract for a scientific meeting or for publication during residency. Residents may elect to do a block of research during residency. Residents should expect to attend one funded scientific meeting during their residency. If the resident has a paper accepted for presentation at a scientific meeting, every effort will be made to allow attendance on TDY status. All PG2's and PG'3 are encouraged to submit a Society of Air Force Physician paper or project no later than October of each year for the spring meeting.

VII. **Evaluations**

A. The resident must clearly understand what performance is expected of him/her at the start of each rotation. Goals and objectives are to be discussed at the beginning of each block rotation and documentation that this has occurred is a required part of the residents record.

The resident should expect verbal preliminary evaluation at the midpoint of each rotation. At the end of each 4-week rotation, the resident will receive a written evaluation by the supervising staff physician, which should be reviewed with the resident and signed in person.

B. The resident is encouraged to provide a carefully written evaluation of the interns on his/her team when he/she serves as a ward or ICU resident. These evaluations should be completed in a prompt and constructive manner.
C. All residents will take the ABIM In-training examination (10-17 October 2003). Do not plan to take leave during this time. This exam will not be used to formally evaluate the resident, but should be used by the individual to assess his/her progress and depth/breadth of knowledge to direct self-study.
D. The Department of Medicine Residency Education Committee (REC) periodically reviews the performance of each resident. If it becomes apparent that a resident is not progressing satisfactorily, the REC, with the approval of the Program Director, may elect to provide that resident with more intense staff supervision and guidance in order to allow an opportunity for improvement in academic and/or clinical skills. If a resident is judged to have an unsatisfactory performance, the REC, with the approval of the Program Director, may place him/her on informal interdepartmental probation (I.E., "Academic Notice"), and establish a remedial program specifically designed to meet his/her special needs. If significant problems persist with a resident's performance, formal probation or even dismissal from the program may be recommended by the REC, the Program Director, and the Director of Medical Education (in cooperation with the Hospital Professional Education Committee), as outlined by Air Force regulation.
E. The resident will keep a procedure book summarizing all procedures performed, the name and ID number of the patient, indications, the signature of the individual that supervised the procedure, and complications. Carbon copies of these entries will be submitted at least monthly. Please review the summary of your procedure logs every 6 months to insure your have completed all requirements to sit for your boards.
F. At the end of each 4-week rotation, all residents are required to frankly and constructively critique their Staff Physician on the forms provided by the Chief Resident.

VIII. **Outside Employment**

"Moonlighting" (i.e. outside employment in a medical position) by any house officer is not allowed.

IX. **Special Requirements**

All PG2 and PG3 residents should maintain a medical license in the state of their choice in order to facilitate extramural rotations at other medical facilities. All PG2 residents are required to have a state medical license by the end of the PG2 year (30 June).

X. **Autopsies**

A. Autopsies must be requested on all deaths in accordance with California state law.
B. The A&D department and Pathology strive to notify each intern/resident of scheduled autopsies. The ward or ICU resident should ensure that he/she and the intern for the

patient in question attends the autopsy; oftentimes, key clinical data can be relayed to the pathologist at the time of autopsy.

C. An autopsy book with records of all performed autopsies of the medicine department is kept in the medicine office and needs to be periodically reviewed by the resident to find out official results.

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